BEFORE THE MINNESOTA

BOARD OF PHYSICAL THERAPY

In the Matter of the
Physical Therapy License
of Paul A. Holmquist, P.T.
Date of Birth: 9/08/1962
License Number: 3080

STIPULATION AND ORDER

IT IS HEREBY STIPULATED AND AGREED, by and between Paul A. Holmquist, P.T. ("Respondent"), and the Complaint Review Committee ("Committee") of the Minnesota Board of Physical Therapy ("Board") as follows:

1. During all times herein, Respondent has been and now is subject to the jurisdiction of the Board from which he holds a license to practice physical therapy in the State of Minnesota.

2. Respondent has been advised by Board representatives that he may choose to be represented by legal counsel in this matter. Although aware of his right to representation by counsel, Respondent has knowingly and expressly waived that right. The Committee was represented by Nathan W. Hart, Assistant Attorney General, 445 Minnesota Street, Suite 1400, St. Paul, Minnesota 55101-2131, telephone (651) 296-7575.

FACTS

3. For the purpose of this stipulation, the Board may consider the following facts as true:

a. Respondent was licensed to practice physical therapy in Minnesota on July 2, 1986. At all times material hereto, Respondent was employed at a clinic in Burnsville, Minnesota.

b. Respondent provided physical therapy services to patient #1 for six treatment sessions in one month. Respondent's records for patient #1 do not contain the following:

1) A systems review;

2) Muscle strength test findings;

3) Movement assessment findings (e.g., instability of scapula with active resistive shoulder movement);

4) Posture status;

5) Details of ADL requirements and limitations (e.g., sitting, standing, cooking, vacuuming, driving, and specific limitations currently present);

6) Objective, measurable limitations (e.g., amount of sleep without disturbance, ADL tasks limited or not able to perform);

7) Cervical assessment findings (e.g., ROM, joint mobility, strength, sensory test findings);

8) Details of pain elicited with dressing (e.g., overhead reach putting on and taking off shirt, reach behind back for shirt sleeve, pulling on slacks or socks); and

9) Functional outcomes and treatment goals stated in objective, measurable terms.

c. Respondent's plan of care for patient #1 does not specify the type of treatment interventions planned, reflect the need for skills and judgment of a physical therapist to administer treatment, instruction in patient home exercise program, or instruction in patient self-management techniques.

d. Respondent failed to include the following information when documenting services/intervention he provided to patient #1, as demonstrated by the following:

1) Details of specific treatment interventions provided on each date of service;

2) A description of the skills and judgment required and used by Respondent to administer the treatment;

3) Home self-management instructions;

4) Instruction in home exercise program;

5) Impact of treatment, resolution of tendonitis, and impact of decrease in pain on the patient's functional abilities (e.g., sleep disturbances, dressing, ADLs); and

6) Criteria for discharge or discharge planning.

e. Patient #2 was treated by Respondent for 37 treatment sessions in seven months.

f. Respondent's records for patient #2 do not contain a patient informed-consent form.

g. Respondent's documentation of his initial examination/evaluation for patient #2 does not contain the following:

1) A systems review;

2) Muscle strength test findings;

3) Functional movement/stability assessment findings;

4) Details of ADL requirements and limitations (e.g., sitting, standing, driving, and specific limitations currently present);

5) Functional limitations stated in objective, measurable terms (e.g., amount of sleep without disturbance, ADL tasks limited or not able to perform);

6) Details of activities that result in headaches toward end of day (e.g., type of activity, length of time performed, posture activity performed); and

7) Functional outcomes and treatment goals stated in objective, measurable terms.

h. Respondent's plan of care for patient #2 does not specify the type of treatment interventions planned, reflect the needs for the skills and judgment of a physical therapist to administer treatment, a home exercise program, or self-management techniques.

i. Respondent's documentation of his interventions with patient #2 does not contain the following:

1) Details of the specific treatment interventions provided each date of service;

2) A description of the skills and judgement required and used by the physical therapist to provide or administer the treatment or rationale for the decisions made;

3) Home self-management instructions; and

4) Instruction in home exercise program.

j. Respondent's documentation of his re-examination of patient #2 does not contain the following:

1) Strength test results;

2) Soft-tissue assessment findings;

3) Functional assessment to determine why an increase in ADLs caused exacerbation of headaches;

4) Details of home exercise and self-management program;

5) The physical therapist's critical-thinking and decision-making that reflects consideration of alternatives to ongoing in-clinic treatment and rationale stated in objective, measurable terms for rejecting those alternatives; and

6) Rationale for the medical necessity of continued treatment.

k. In his discharge note for patient #2, Respondent documented implied discharge criteria of increased strength and statement of no headaches but did not document any criteria for discharge or discharge planning stated in objective, measurable terms.

l. Respondent failed to provide appropriate supervision of the physical therapist assistant on or before the sixth treatment session on June 30, 2009.

m. Patient #3 was seen by Respondent for 20 treatment sessions in five months.

n. Respondent's records for patient #3 do not contain a patient informed-consent form for services.

o. Respondent's documentation of his initial examination/evaluation of patient #3 does not contain the following:

1) A systems review;

2) Muscle strength test findings; and

3) Functional movement/stability.

p. Respondent's documentation of his interventions for patient #3 does not contain the following:

1) Details of the specific treatment or interventions provided each date of service (e.g., type, intensity, specific area of mobilization, myofascial release);

2) Details of provider observations and findings after treatment;

3) Details of body mechanics training; and

4) Details of home exercise program and self-management techniques.

q. Respondent's documentation of his re-examination of patient #3 does not contain the following:

1) Soft-tissue assessment findings;

2) Functional assessment to determine abilities and/or lack of abilities to perform ADLs and job duties;

3) Details of home exercise and self-management program;

4) Progress or lack of progress in ROM;

5) Posture status;

6) Details of plan of care; and

7) Rationale for medical necessity of ongoing, continued treatment.

r. Respondent's documentation of his discharge for patient #3 lacks specific criteria defining independent status and how it will be measured to determine when reached.

s. Respondent's documentation for patient #3 contains no indication that Respondent coordinated his plan of care with patient #3's referring physician, or had any communication with the referring physician.

STATUTES

4. The Committee views Respondent's practices as inappropriate in such a way as to require Board action under Minn. Stat. § 148.75(a)(1) (violated statute or order Board is authorized to enforce), (6) (unprofessional conduct), and (11) (inadequately supervised a

physical therapist assistant) (2008). Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify the disciplinary action under these statutes.

REMEDY

5. Upon this stipulation and all of the files, records, and proceedings herein, and without any further notice or hearing herein, Respondent does hereby consent that until further order of the Board, made after notice and hearing upon application by Respondent or upon the Board's own motion, the Board may make and enter an order **CONDITIONING** and **RESTRICTING** Respondent's license to practice physical therapy in the State of Minnesota as follows:

a. Respondent is hereby **REPRIMANDED** for the conduct referenced above.

b. Respondent shall submit to and cooperate with reviews performed by the Problem Identification/Peer Review Committee of the Minnesota Chapter of the American Physical Therapy Associations ("MNAPTA"). Reviews shall be quarterly the first year and semiannual in subsequent years. Each year, one peer review shall include on-site observation of treatment in addition to the review of physical therapy records and billing procedures. All reviews shall include chart audits and billing reviews. Respondent is further responsible for ensuring the Board, or its designee, receives reports from MNAPTA regarding the findings of each review performed.

c. Respondent shall successfully complete a documentation course offered by MNAPTA.

6. Respondent is responsible for all costs incurred as a result of compliance with this Stipulation and Order.

7. This Stipulation and Order shall remain in effect for a minimum of two years. At the end of this period, Respondent may petition for reinstatement of an unconditional license. Upon hearing the petition, the Board may continue, modify, or remove the conditions set out herein.

8. Within ten days of the date of this Order, Respondent shall provide the Board with a list of all hospitals and skilled nursing facilities at which Respondent currently has privileges, a list of all states in which Respondent is licensed or has applied for licensure, and the addresses and telephone numbers of Respondent's residences and all work sites. Within seven days of any change, Respondent shall provide the Board with the new address and telephone information. The information shall be sent to Stephanie Lunning, Minnesota Board of Physical Therapy, University Park Plaza, 2829 University Avenue S.E., Suite 420, Minneapolis, Minnesota 55414-3664.

9. In the event Respondent resides or practices outside the State of Minnesota, Respondent shall promptly notify the Board in writing of the location of his residence and all work sites. Periods of residency or practice outside of Minnesota will not be credited toward any period of Respondent's suspended, limited, or conditioned license in Minnesota unless Respondent demonstrates that practice in another state conforms completely with Respondent's Minnesota license to practice physical therapy.

10. If Respondent shall fail, neglect, or refuse to fully comply with each of the terms, provisions, and conditions herein, the Committee shall schedule a hearing before the Board. The Committee shall mail Respondent a notice of the violation alleged by the Committee and of the time and place of the hearing. Respondent shall submit a response to the allegations at least

three days prior to the hearing. If Respondent does not submit a timely response to the Board, the allegations may be deemed admitted.

At the hearing before the Board, the Committee and Respondent may submit affidavits made on personal knowledge and argument based on the record in support of their positions. The evidentiary record before the Board shall be limited to such affidavits and this Stipulation and Order. Respondent waives a hearing before an administrative law judge and waives discovery, cross-examination of adverse witnesses, and other procedures governing administrative hearings or civil trials.

At the hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Respondent's practice, or suspension or revocation of Respondent's license.

11. In the event the Board in its discretion does not approve this settlement, this stipulation is withdrawn and shall be of no evidentiary value and shall not be relied upon nor introduced in any disciplinary action by either party hereto except that Respondent agrees that should the Board reject this stipulation and if this case proceeds to hearing, Respondent will assert no claim that the Board was prejudiced by its review and discussion of this stipulation or of any records relating hereto.

12. Respondent waives any further hearings on this matter before the Board to which Respondent may be entitled by Minnesota or United States constitutions, statutes, or rules and agrees that the order to be entered pursuant to the stipulation shall be the final order herein.

13. Respondent hereby acknowledges that he has read and understands this stipulation and has voluntarily entered into the stipulation without threat or promise by the Board or any of its members, employees, or agents. This stipulation contains the entire agreement between the

parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this stipulation.

Dated: 10-29-10

SIGNATURE ON FILE

PAUL A. HOLMQUIST, P.T.
Respondent

Dated: 11/18/10

SIGNATURE ON FILE

FOR THE COMMITTEE

ORDER

Upon consideration of this stipulation and all the files, records, and proceedings herein,

IT IS HEREBY ORDERED that the terms of this stipulation are adopted and implemented by the Board this 18th day of November, 2010.

MINNESOTA BOARD OF
PHYSICAL THERAPY

SIGNATURE ON FILE

STEPHANIE LUNNING
Executive Director

AG: #2707646-v1